Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014-12/31/2014

Coverage for: Individual, Family | Plan Type: HDHP



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthscopebenefits.com or by calling 1-800-266-9217.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Healthlink HMO/PPO, Freedom Network/Select, \$2,500 Individual/ \$5,000 Family. Out-of-Network: \$3,000 Individual / \$6,000 Family.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-</u> <u>pocket limit</u> on my expenses?	Healthlink HMO/PPO, Freedom Network/Select: \$2,500 Individual / \$5,000 Family. Out-of-Network: \$4,000 Individual / \$8,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u> <u>limit?</u>	Amounts over Usual and Customary Fees, penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See www.healthlink.com or call 1-800-266-9217 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 5. Numbers See your policy

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-266-9217 to request a copy.

OMB Control 1545-2229, 1210-0147, and 0938-1146

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plan doesn't cover?	or plan document for additional information about <u>excluded services</u> .



- <u>Co-payments</u> are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Co-insurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>co-insurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use Network <u>providers</u> by charging you lower <u>deductibles</u>, <u>co-payments</u> and <u>co-insurance</u> amounts.

Common		Your cost if you use		Limitations &
Medical Event	Services You May Need	Healthlink HMO/PPO, Freedom Network/Select	Out-of-Network	Exceptions
	Primary care visit to treat an injury or illness	No charge	30% coinsurance	none——
If you visit a health	Specialist visit	No charge	30% coinsurance	none
If you visit a health care <u>provider's</u> office or clinic	Other practitioner office visit	No charge for Chiropractor or Acupuncture / Acupressure	30% coinsurance for Chiropractor or Acupuncture / Acupressure	none
	Preventive care/screening/ immunization	No charge	No charge	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Pre-certification required for MRI, MRA and PET scans.

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Common		Your cost if you use		Limitations &
Medical Event	Services You May Need	Healthlink HMO/PPO, Freedom Network/Select	Out-of-Network	Exceptions
If you need drugs to	Generic drugs	No charge	Not covered	none
treat your illness or condition	Preferred brand drugs	No charge	Not covered	Includes cost difference between brand and generic forms if generic is available.
More information about prescription drug coverage is available at	Non-preferred brand drugs	No charge	Not covered	Includes cost difference between brand and generic forms if generic is available.
www.healthscopebene fits.com.	Specialty drugs	No charge	Not covered	Maximum of 30-day supply per prescription.
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	none
outpatient surgery	Physician/surgeon fees	No charge	30% coinsurance	none
IC	Emergency room services	No charge	No charge	none
If you need immediate medical attention	Emergency medical transportation	No charge	30% coinsurance	none
attention	Urgent care	No charge	30% coinsurance	none
If you have a	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Pre-certification is required.
hospital stay	Physician/surgeon fee	No charge	30% coinsurance	Pre-certification is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	30% coinsurance	none
	Mental/Behavioral health inpatient services	No charge	30% coinsurance	Pre-certification is required.
	Substance use disorder outpatient services	No charge	30% coinsurance	none
	Substance use disorder inpatient services	No charge	30% coinsurance	Pre-certification is required.

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If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	none-
	Delivery and all inpatient services	No charge	30% coinsurance	none
	Home health care	No charge	30% coinsurance	Pre-certification is required.
If you need help	Rehabilitation services	No charge	30% coinsurance	Pre-certification is required.
recovering or have	Habilitation services	No charge	30% coinsurance	Pre-certification is required.
other special health needs	Skilled nursing care	No charge	30% coinsurance	Pre-certification is required.
	Durable medical equipment	No charge	30% coinsurance	Pre-certification is required.
	Hospice service	No charge	30% coinsurance	none
If your child needs dental or eye care	Eye exam	No charge	No charge	Screening under Preventive Care for children under 5.
	Glasses	Not covered	Not covered	none
	Dental check-up	Not covered	Not covered	none

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
Bariatric Surgery	Long-Term Care	Routine Foot Care	
Cosmetic Surgery	Routine Eye Care (Adult)	Weight Loss Programs	
Hearing Aids			

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
Acupuncture	Dental Care (Adult – Injury only)	 Non-emergency care when traveling outside the U.S.
Chiropractic Care	• Infertility Treatment (\$15,000 maximum per family per lifetime)	Private Duty Nursing

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-266-9217. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: HealthSCOPE Benefits at 1-800-266-9217.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.



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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,890
- Patient pays \$2,650

Sample care costs:

Total	\$7,540
Vaccines, other preventive	\$40
Radiology	\$200
Prescriptions	\$200
Laboratory tests	\$500
Anesthesia	\$900
Hospital charges (baby)	\$900
Routine obstetric care	\$2,100
Hospital charges (mother)	\$2,700

Patient pays:

· anoni payor	
Deductibles	\$2,500
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$2,650

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,400
- Patient pays \$0

Sample care costs:

Prescriptions	\$2, 900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

payer	
Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$0

The Managing Type 2 Diabetes example assumes the patient is participating in the Plan's Disease Management program which covers diabetic maintenance costs at 100%.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include <u>premiums</u>.
- Sample care costs are based on national averages supplied by the U.S.
 Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>co-insurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>co-payments</u>, <u>deductibles</u>, and <u>co-insurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.